HEALTH PLANNING: ISSUES FOR REAUTHORIZATION

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In line 6 of the second paragraph, the estimate of increased revenue should be $2.8 billion, not $1.8 billion.

PREFACE

The Congress is now considering reauthorization of the health planning program. This paper, prepared at the request of the Senate Labor and Human Resources Committee, examines the background and effects of the program, and discusses options for continuing or changing the federal role in health planning. In keeping with the Congressional Budget Office's mandate to provide objective and impartial analysis, this study offers no recommendations.

Lisa A. Potetz of the Human Resources and Community Development Division of the CBO prepared the paper, under the supervision of Nancy M. Gordon and Paul B. Ginsburg. The author wishes to thank a number of people for their valuable contributions, particularly Brian Biles, Harry Cain, Judy Lewis, and Malcolm Curtis, and many individuals involved in health planning at the federal, state, and local levels. Patricia H. Johnston edited the manuscript. Reba Williams, along with Mary Braxton and Jill Bury, typed the earlier drafts and prepared the paper for publication.

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SUMMARY

The federal health planning program, authorized by the National Health Planning and Resources Development Act of 1974, funds state and local planning agencies that assess area health needs, set priorities, and attempt to direct health-care resources to the most needed services and locations. These agencies also conduct certificate of need (CON) review of proposed construction and major equipment purchases by health facilities--their major tool for controlling hospital costs.

Funding for health planning averaged about $130 million annually between 1976 and 1981, but was reduced to $58 million in fiscal year 1982. Authorization for the program expires at the end of this year, and the Administration has proposed terminating it at that time.

The health planning program addresses a number of problems associated with the allocation of health resources--excess capacity, unnecessarily duplicated services, high hospital costs, and unevenly distributed health services. These problems result primarily from two sets of factors: those that encourage overinvestment--extensive third-party reimbursement, competition among hospitals for physicians, and the availability of tax-exempt financing, in particular; and those that result from the exclusion of consumers from decisions determining the kind of available health care.

Through funding local and state agencies, the health planning program attempts to redirect resources to better reflect patient needs at lower costs. The 1974 act requires that health-care consumers must be major participants in this process, as well as providers and insurers. Access to care, costs, and quality are all factors to be considered in developing health plans.

THE EFFECTS OF HEALTH PLANNING

Although available evidence does not support the hypothesis that CON review has restrained growth in aggregate hospital investment or costs, these results must be interpreted with

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caution. First, evaluations of CON review reflect decisions made before the implementation of the federal law. If CON programs have become more effective as a result of federal requirements and funding, the gains would not have appeared in these studies.

Second, despite the fact that studies did not find aggregate effects from CON review, a few individual state programs may have been successful at restraining growth in hospital investment and costs. Since the studies were designed to measure the national average effects of CON review programs, effects of successful programs could have been diluted sufficiently by the experience in other states to preclude measurement of restraining CON effects in the aggregate. Third, the studies have other technical limitations that could preclude identifying effects.

Even if total investment and costs are not affected, CON review may affect the mix of capital projects. Hospitals may be forced to shift investment toward those projects favored by health planning agencies because others might be denied.

Although the effect of CON review on hospital investment and costs has been the focus of most evaluations of health planning, agencies have emphasized this goal to varying degrees. The planning act requires a number of other goals, such as improving access to care and promoting quality care, that can conflict with that of containing costs. In addition, cost containment was not added as a specific national priority until 1979, and many agencies perceive other goals as more important.

Anecdotal evidence of planning agency successes with other goals exists, but there have been no systematic evaluations of the effects of these efforts. Some results--improved quality of care, for example--are difficult to measure, and the role of planning agencies in affecting these results cannot easily be separated from other factors.

PROBLEMS WITH THE HEALTH PLANNING PROGRAM

A number of problems limit the potential of the current health planning program to meet its goals, particularly cost containment. Five of them could be at least partially solved through program changes. First, unclear and conflicting goals have limited the effectiveness of health planning. The broad mandate given by the planning act and sometimes poor communication between the federal government and state and local planning agencies have

contributed to the problem. Second, planning agencies have little authority other than using powers of persuasion to implement their goals. CON review is the only direct authority available, and agencies can act only to deny projects in response to proposals made by providers. Third, hospitals are reluctant to accept planning agency recommendations to merge, share services, or otherwise cooperate because such actions might lead to antitrust suits. Fourth, because hospitals can invest in services and equipment that are not subject to CON review, the potential effect on total investment and costs is reduced. Fifth, federal requirements, such as those for representative local governing boards and comprehensive health plans, may have absorbed agency resources without improving effectiveness.

Three general problems with health planning would be more difficult to address with program changes. First, the absence of a scientific basis for standards makes them subject to challenge. Quantitative guidelines upon which planning agency activities are to be based are somewhat arbitrary because of a lack of knowledge about how health services translate into improved health. In addition, detailed data on the health status of local populations are not available and can be expensive to gather. Second, because the costs of overinvestment are often shared by areas larger than the ones covered by the local planning agencies, local reviewers have little incentive to deny services for their area. In addition, providers may be able to dominate the process because of their expertise. Third, the costs of CON review--including those to hospitals applying for project approval--offset any savings from deferred projects. The extent of this problem is unknown.

OPTIONS

Four broad options for changing the health planning program are available, including:

- o End the requirement for planning and eliminate federal funding for the program (Administration proposal);
- o Continue a federal role in health planning, either by maintaining the current program with changes to focus on cost containment or by providing federal grants only to states that chose to continue planning programs;
- o Encourage state hospital cost-containment programs by including funds for health planning as part of a performance contract;

- o Eliminate tax-exempt bonds for private hospital construction.

End the Federal Role in Health Planning (Administration Proposal)

The Administration's proposal would discontinue the federal planning program after fiscal year 1982, in favor of measures to increase competition in health care in order to contain costs. Under this option, states could maintain their own planning programs should they desire, but federal funds would not be available. Most states are expected to continue CON review, but local planning would be eliminated in most areas.

This option would reduce federal spending, eliminate regulation in states that discontinue CON review, and would probably not significantly affect aggregate hospital investment and costs. There is no evidence that, in the aggregate, CON review has restrained growth in hospital investment or costs, although studies are limited. It is possible that some individual states have had successful programs, but they would not be likely to discontinue CON review. Also, financial analysts predict that there will be limited opportunities for hospitals to finance expensive investments in coming years.

The risk of a less likely but costly scenario exists, however. Some observers contend that, because the incentives for investment would remain, ending the health planning program could lead hospitals to step up their investment plans. To the extent that any successful state CON review programs would either be ended or become less effective without federal support--and if enough financing was available--hospitals could increase capital spending, leading to faster growth in hospital costs and higher outlays for Medicare and Medicaid.

The Administration's proposal could change the mix of projects undertaken. In states that abandon CON review, hospitals would no longer have to develop projects that planning agencies approve. To the extent that planning agency goals differ from those of providers, this could alter the location and types of projects.

Ending the federal health planning program probably would not affect competition among hospitals appreciably, but could impede competition from Health Maintenance Organizations (HMOs). Some state laws do not exempt these organizations from CON review as required by the planning act, and more might drop the exemption if the requirement is withdrawn.

Continue a Federal Role in Health Planning

Federal participation in planning would continue under this option, in one of two ways. One approach would maintain the current program with changes to increase the focus on cost containment. The other approach would end the requirement for planning but offer federal grants to states that chose to continue a planning program.

One reason put forth in favor of maintaining a federal role in health planning is that the program has not been adequately evaluated. As discussed earlier, available studies do not reflect the impact of the federal program and have technical limitations.

Another reason is that the federal government--which pays for 32 percent of total hospital expenditures--benefits from any success in cost containment. Although Medicare and Medicaid savings from a continued federal program may be too small to show up in the evaluations of CON review, they might nevertheless exceed federal outlays for health planning.

Finally, if federal funds are withdrawn, the expected cutbacks in data collection and analysis could reduce the ability of continuing state CON programs to identify the most needed projects. This problem would be particularly serious if the availability of funds for hospital investment is limited, as is expected in the near future.

Maintain the Planning Program with Modifications. This approach would continue the planning program and attempt to increase its effectiveness by focusing more on cost containment. Continued federal spending would be required, however, and these changes might not improve the performance of CON review, particularly in those states without a commitment to its success. Examples of changes that could be made include:

- Make cost containment the major program goal;
- Alter federal CON requirements to target review only on the potentially most costly projects;
- Grant exemptions from antitrust laws when hospitals act in accordance with recommendations by health planning agencies;
- Change some federal process requirements, such as those for health plans and governing board membership; and

o Consolidate health systems areas.

Offer Grants to States. A second approach to maintain a federal role would end the requirement for state and local planning, but offer grants and technical assistance to states that chose to maintain a planning program. Grants could be awarded in one of several ways--by application, on a formula basis, as part of a block grant for cost containment programs--or states could require hospitals to help fund health planning, with the federal share collected by including these payments as an allowable cost under Medicare and Medicaid.

Under this strategy, states that believe their programs have been successful at controlling costs or improving the distribution or quality of health services could continue them, while those that are not interested in planning could drop their programs. On the other hand, federal funding might not increase the number of states continuing CON review, or the effectiveness of the programs. In addition, this approach might interfere with regional planning. Fifteen major metropolitan areas have local planning agencies that cross state boundaries, presenting a potential problem should adjoining states disagree about whether to maintain planning.

Encourage State Hospital Cost-Containment Programs

The third option would offer states an incentive for hospital cost containment by sharing resulting Medicare savings. States that held growth in hospital expenditures to a predetermined level would receive a share of the estimated savings in Medicare reimbursements. States could choose the cost-containment method--CON review, rate review, voluntary programs, for example, or a combination of approaches. States choosing CON review could be required to have health plans and to exempt HMOs from review.

Depending on the extent to which states would begin new programs, total federal expenditures could increase or decrease. States with mandatory rate review have been successful at slowing the rate of growth in hospital costs and if new successful programs are begun, federal savings could be achieved. Some states are philosophically opposed to regulation, however. Others might begin programs even without the federal incentive, as a result of Medicaid budgetary pressures. If states that already have programs would receive more in federal payments than the savings generated from adoption of new cost containment programs, federal expenditures would actually increase.

Eliminate Tax-Exempt Bonds for Private Hospital Construction

Eliminating tax-exempt financing for private hospitals would reduce the availability of funds for hospital construction projects, thereby limiting overall investment. Up to $2.8 billion in federal revenues would be added over fiscal years 1983 to 1987, although roughly one-third of the impact on the federal deficit could be offset by increased Medicare and Medicaid payments to hospitals.

Although this proposal would shrink the pool of funds available for hospital investment, it would not necessarily have the same effects as continuing health planning. Because investments would be made on the basis of hospitals' financial standing, some projects that would have been disapproved by CON review would be financed, whereas ones that would have been approved might not. Hospitals with a relatively high proportion of Medicare and Medicaid patients would find it more difficult to obtain financing for projects, and nonprofit hospitals would be affected more than proprietaries, because the latter currently have limited access to tax-exempt financing.

CHAPTER I. INTRODUCTION AND BACKGROUND

In recent years, rapidly rising hospital costs have contributed to significant increases in federal outlays for health-care programs. Inpatient hospital costs rose at an average annual rate of about 15 percent between 1970 and 1981. Federal Medicare and Medicaid outlays for hospital services rose about 17 percent a year during this period, to an estimated $32.4 billion in fiscal year 1981. Moreover, hospital costs are expected to continue their rapid growth in coming years.

Excess investment in hospital construction and equipment, leading to both unnecessary duplication of expensive facilities and overuse of hospital services, is a major cause of the growth in hospital costs. Several factors have contributed to over-investment: the prevalence of third-party payment for hospital care, which removes the incentive for patients to demand cost-effective treatment; hospital competition for physicians through offering the latest techniques and equipment; and the availability of federal subsidies to finance capital investments.

THE FEDERAL ROLE IN HEALTH PLANNING

The intent of the federal health planning program, as authorized by the National Health Planning and Resources Development Act of 1974, is to prevent unnecessary and costly hospital investment and to improve the distribution of health-care services. The act created a network of state and local planning agencies. The latter, called Health Systems Agencies (HSAs), are composed of representatives of local health-care providers, consumers, and insurers that analyze the need for health services in their areas. The 1974 act also mandated that states enact certificate of need (CON) legislation requiring state agency approval for hospital investment in new facilities, equipment, or services, in conformance with local and state planning agency goals.

As the Congress discusses the reauthorization of the health planning act in 1982 it will need to consider the following questions:

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- What has been the experience of health planning in containing hospital costs? Although cost containment did not become an explicit federal priority until the 1979 amendments (Public Law 96-79), it has been the most common basis for judging the success of the planning program.

- Does health planning limit competition? The Administration proposes to end health planning, in part on the grounds that it has limited competition among health facilities, and interferes with its goal of increasing competition.

- What have been the effects of federal requirements for health planning? Some states had CON review programs before the 1974 Act, and most of these would maintain them even if the federal requirements were repealed. Most local planning agencies would not survive, however.

Funding for Health Planning

From fiscal years 1976 through 1981, federal expenditures for health planning averaged $130 million annually. HSAs received 75 percent of these funds; state planning agencies, 21 percent; and Centers for Technical Assistance, which provide support for local agencies, the remaining 4 percent (see Table 1).

As a result of Administration efforts to reduce federal spending, the Congress voted to rescind $18 million from the fiscal year 1981 appropriation for local health planning.[1] This action reduced 1981 funding for HSAs to $82.9 million, an 18 percent cut.

The Continuing Resolution (Public Law 97-92) appropriated $58.2 million for the entire planning program in fiscal year 1982, a 63 percent cut from 1980 funding levels. HSA funding was reduced by about 70 percent.

Plan of the Paper

This paper presents an overview of the federal health planning program, assesses its effectiveness, and analyzes options for

1. A rescission for consulting fees for the Department of Health and Human Services resulted in an additional cut of $0.8 million for HSAs and $0.3 million for state agencies.

TABLE 1. APPROPRIATIONS FOR HEALTH PLANNING, FISCAL YEARS 1975-1982 (In millions of dollars)

	1975	1976	1977	1978	1979	1980	1981	1982[a]
Local Planning Agencies	0	64.1	97.0	107.0	107.0	124.7	82.9[b]	37.7
State Planning Agencies	0	19.0	24.5	29.5	29.5	32.0	31.7	19.2
Centers for Technical Assistance	10	7.5	6.5	6.5	6.5	1.0	1.7	1.3
Total	10	90.6	128.0	143.0	143.0	157.7	116.3	58.2

a. Appropriations under the Continuing Resolution (Public Law 97-92) which provides funds through March 31, 1982.

b. The $18.8 million recission for 1981 has been deducted to arrive at this number.

change. The remainder of this chapter examines the rationale for health planning. Chapter II explains how the federal health planning program operates. Chapter III examines the effectiveness of health planning by analyzing evaluations of CON review, and discusses problems with the health planning program. Chapter IV analyzes options for changing the program and the probable effects of these changes.

PURPOSES OF HEALTH PLANNING

The health planning program is intended to improve the distribution of health services to ensure that they are available to those who need them and to restrict investment in unnecessary facilities and services. Problems of medically underserved areas and investments in duplicate facilities that are rarely used were factors motivating federal participation in planning activities.